# Cosmetique Plastic Surgery, Inc

**Today's Date:** _____

**Name:** _____
**Last** **First** **M.I.**

**Local Address:** _____
_____ **zip code**_____

**Permanent Address:** _____
_____ **zip code**_____

**Telephone: H**_____ **Wk**_____ **Cell/bpr**_____

**Birth date:**_____ **Sex: M F Marital Status: M S W D Sep.**

**Occupation:**_____ **Employer:** _____

**Reason for consultation:** _____

**How were you referred to us?** _____

**Have you seen other surgeons for this? Who? When?** _____
_____

**PATIENT SIGNATURE** _____

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## Medical Information

1. Reason for consultation_____

2. List all previous surgeries/hospitalizations, including reason

| Surgery/Hospitalization/Reason | General Anesthesia? Y/N |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

3. List all medications you are taking, including eye drops and ointments

| Medication | Dosage | How often |
|---|---|---|
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |

4. Check any of the following diseases which you have or have had

___Emphysema
___Asthma
___Bronchitis
___Pneumonia
___Stroke
___Glaucoma
___Diabetes
___Skin Cancer
___Cataracts
___High/Low Blood Pressure
___Heart Murmur
___Irregular/Fast Heartbeat
___Seizure Disorder/Epilepsy
___Congenital Heart Disease
___ Excessive Bleeding
___ Heart Attack
___Nervous Breakdown
___Liver Disease/Hepatitis/Jaundice
___Tuberculosis
___Cancer
___HIV/Aids
___Angina
___Rheumatic Fever
___Thyroid Disorder
___Dry Eye Syndrome
___Psychiatric Care

5. FAMILY HISTORY: List immediate family members, either deceased (with cause of death and age) or living with serious illness.

_____
_____
_____

Any family history of breast cancer? Yes___ No___ If yes, who?_____
_____

Patient Signature:_____

6. SOCIAL HISTORY: Please check and answer all of the following:

| Y | N | |
|---|---|---|
| | | Do you have any skin problems? If yes, please describe: |
| __ | __ | Rash _____ |
| __ | __ | Bruising _____ |
| __ | __ | Other _____ |
| __ | __ | Do you smoke? If yes, how many per day? _____ |
| __ | __ | Are you a former smoker? If yes, when did you stop? _____ |
| __ | __ | Do you drink alcoholic beverages? If yes, how much per day? _____ |
| __ | __ | Do you have vision problems? If yes, please explain: _____ |
| | | _____ |
| __ | __ | Do you wear eye glasses? |
| __ | __ | Do you wear contact lenses? |
| __ | __ | Do you wear a removable dental appliance/denture? |
| __ | __ | Do you now, or have you ever used "street drugs"? |
| __ | __ | Do you have allergies to medications or environment? If yes, explain: __ |
| | | _____ |
| __ | __ | Do you have breathing problems? If yes, explain: _____ |
| | | _____ |
| __ | __ | Do you have any disease, condition, or problem not listed that you think the doctor should know about? If yes, explain: |
| | | _____ |
| | | _____ |
| | | _____ |

7. PRIVATE/PERSONAL PHYSICIAN: _____

Phone Number: _____

Address: _____

Date of last exam: _____

Date of last EKG: _____

Last known blood pressure: _____

Date of last Mammogram: _____

I have read (or have had read to me) the above medical information listing and I hereby certify that the information I have provided is correct.

Signed: _____ Date: _____